

Date 11/19/19 230	#1	DDAVP 0.8mg ÷ QHS x 365	Name	Smith, Jacob
			AO	41666
	#2	f/u to urology in 3 months RBO Dr. Rees / ZBKW	Allergies:	
	#3		Unit - WRC A B <u>C</u> D INF HSU1 HSU2 LHU2 MDIU LHU1	
			Medication Issued From Stock	
			1 # _____ 2 # _____ 3 # _____	
			Date	11/19/19 Initials ZBKW

Date 12-19-19	#1	PAID CLINIC 1-2 ACS	Name	Smith, Jacob
		Dx BILAT. KNEE EFFUSION	AO	41666
	#2	LABS CBC BMP PREE	Allergies:	
	#3		Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1	
			Medication Issued From Stock	
			1 # _____ 2 # _____ 3 # _____	
			Date	12/19/19 Initials KW

Date 2/6/20	#1	Please schedule with Dr. Rees to re-evaluate	Name	Smith, Jacob
			AO	41666
	#2	need for tx. of left index finger.	Allergies:	
	#3		Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1	
			Medication Issued From Stock	
			1 # _____ 2 # _____ 3 # _____	
		T. Boese KW	Date	2/6/20 Initials TB

Date 2/28/20	#1	ANA, ESR, RF	Name	Smith, Jacob
		Dx CHRONIC KNEE EFFUSION	AO	41666
	#2		Allergies:	
	#3		Unit - WRC A B C D INF HSU1 HSU2 LHU2 MDIU LHU1	
			Medication Issued From Stock	
			1 # _____ 2 # _____ 3 # _____	
			Date	2/28/20 Initials TB



Montana Department of Corrections

Nursing and Provider Progress Notes

T: 98 ²	P: 56	RR: 16	BP: 117/69	O2 Stats: 99	Height: 6'0"	Weight: 220	Age: 44
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Routine Follow Up: Schedule back with Dr. Rees to discuss knee daed 7.23.19 and urinary plan of care see 3.4.19 note from Dr. Readal per SP 7.26.19

PT REPORTS 50% RELIEF IN NOCTURNAL POLYURIA. DDAVP 9HS PT HAS BEEN ON MED CONTINUOUSLY FOR 2-3 DAYS PREVIOUSLY WHEN PT EXPERIENCED H.A's.

Rx 8 BENIGN FUPDUS. IT-RRR L-CLEAR A. SHUT E- BELAT MOD. KNEE EFFUSIONS. GOOD ROM & LEG INSTABILITY.

A) DETRUSOR INSTABILITY
BELAT. KNEE EFFUSIONS ≈ 4 NOS
& Hx OF RA.

P) REPEAT BELAT KNEE X RAYS

Provider Signature:		
Offender Name / DOC ID#: Smith, Jacob Lee - 41666	Date: 11/21/2019	Time:

SCHEDULE FOR ARTHROCENTESIS TOMORROW
BACTERIALS II PO IV AM / AT TIME OF
PROCEDURE AND AT HS.

F/U FOR DETRUSOR INSTAB. 4WKS
C/C, BAP ESR RE PRIOR

CONFIDENTIAL MEDICAL INFORMATION - UTILIZE CARE IF DESSEMINATING



Montana Department of Corrections

Nursing and Provider Progress Notes

T: 98 ²	P: 60	RR: 16	BP: 109/67	O2 Stats: 98	Height: 6'0"	Weight: 220	Age: 54
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Routine Referral: Please schedule with Dr. Rees to re-evaluate need for TX of left index finger per TB 2.6.20

INSURED 2016. I SAW 2/10/17

Rx: w/ ACTIVE / PASSIVE STRETCHING PROGRAM.

A) INDEX FINGER & LIMITED FLEXION

BOTH ACTIVE & PASSIVE NO PAIN.

Q SIG A.R. PAIN.

BOTH KNEES & RECURRENT EFFUSIONS.

GOOD ROM.

A) CHRONIC EXTENSOR CONTRACTIONS @ INDEX FINGER

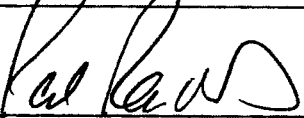
CHRONIC KNEE EFFUSIONS

P) ANA ESR RF

APPT & ORTHO DR. SONES

TREAT OF INDEXED JS TID X 14 D

FU & ME AFTER ORTHO APPT.

Provider Signature: 		
Offender Name / DOC ID#: Smith, Jacob Lee - 41666	Date: 02/28/2020	Time:

CONFIDENTIAL MEDICAL INFORMATION - UTILIZE CARE IF DESSEMINATING

DEFENDANTS 2202



Inmate Name JACOB SMITH
DOC ID# 41666

DEPARTMENT OF CORRECTIONS
MONTANA STATE PRISON

INFORMED CLINICAL CONSENT

I understand that the following clinical procedure; ARTHROCENTESIS & STEROIDS INJ. KNEE
Is recommended by Dr. Rees ☒ Requested by myself ☒
(MDOC Health Care Provider Name)

I have received a clear explanation of my condition, the recommended clinical procedure, the probability of success, treatment alternatives and post procedure expectations/care.

The expected benefit(s) from this clinical procedure is/are: Removal of lesion ☐ Drainage of lesion ☐ Relief of joint inflammation ☒

I have been advised of any significant risks in relation to this clinical procedure. The following reasonably foreseeable risks were discussed: Death, Infection, Scarring, Pain, Loss of function, Nerve damage, Incomplete removal requiring repeat excision ☒

I understand that if the procedure is NOT performed the possible risks are: Progression of lesion/condition, Failure to accurately diagnose, _____

I am aware of my right to give informed consent or informed refusal I, DO ☒ DO NOT ☐ give my informed consent to the recommended procedure.

Patient comment: _____

Signature of Patient [Signature] Date/Time 11/22/19

Signature of Witness [Signature] Date/Time 11/22/19

Patient Refused to Sign _____ Date/Time _____

Witness Signature

DOC 4.5.31 (Attachment) Informed Consent – Revised 4/29/14 (Mod by Rees 11/15/19)

NAME: 31008465911 NUMBER: 41666 UNIT: UC

IN REGARDS TO YOUR REQUEST/KITE

*212100 31008465911 01-11-2020
KITE REQUEST*

P2

- ☐ AN APPOINTMENT AT SICK CALL HAS BEEN SCHEDULED FOR YOU.
- ☐ THE INFIRMARY NO LONGER SUPPLIES THIS.
- ☐ YOU HAVE RECEIVED ALL OF THE MEDICATION ORDERED FOR YOU.
- ☐ THE ITEM(S) CAN BE PURCHASED FROM THE CANTEEN.
- ☐ SEE YOUR UNIT SERGEANT.
- ☐ SEE YOUR UNIT COUNSELOR.
- ☐ IF YOU HAVE FURTHER QUESTIONS, CONTACT THE INFIRMARY VIA KITE.

THE INFIRMARY